



DELAWARE VALLEY HEALTHCARE COUNCIL  
*of The Hospital & Healthsystem Association of Pennsylvania*

## **Obstetrics Services Task Force:**

### **Recommendations and Action Plan for Improved Access to Obstetrics Services in Southeast Pennsylvania**

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**Kate Kinslow, CRNA, Ed.D., MBA, Chair**  
**Executive Director, Pennsylvania Hospital**

**Kenneth J. Braithwaite, II, Senior Vice President**  
**The Hospital & Healthsystem Association of Pennsylvania,**  
**Delaware Valley Healthcare Council**

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## **Table of Contents**

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<b>Executive Summary</b>	<b>3</b>
<b>Introduction</b>	<b>6</b>
<b>Task Force Action Plan</b>	<b>10</b>
<b>Enactment of Legislation to Protect Obstetrics Services</b>	<b>12</b>
<b>Liability Reform</b>	<b>20</b>
<b>Access to Prenatal and Postpartum Care</b>	<b>22</b>
<b>Workforce and Diversity</b>	<b>26</b>
<b>Regulatory Issues</b>	<b>31</b>
<b>Operational and Data Issues</b>	<b>33</b>
<b>Conclusion</b>	<b>39</b>
<b>Acknowledgements</b>	<b>40</b>
<b>Appendices</b>	<b>41</b>
<b>References</b>	<b>44</b>

## Executive Summary

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Obstetric (OB) services in southeast Pennsylvania are under mounting pressure, due in part to the closing of 13 obstetric units and a net loss of six neonatal intensive care units (NICUs) in the last decade. In June 2006, The Hospital & Healthsystem Association of Pennsylvania's Delaware Valley Healthcare Council convened an OB Services Task Force to review access to obstetrical services in the region, address identified issues and concerns, and document these findings. Participating organizations included health care and health insurance providers, state and local health departments, consumer advocacy groups, schools of public health and professional societies.

**Key Findings:** Some women— particularly in large urban and more rural communities – are experiencing problems accessing crucial obstetrical services.

- During the past 10 years, 33 hospital obstetrical units, as well as many neonatal intensive care units, have closed across the Commonwealth.
- The number of licensed OB and obstetrical/gynecological (OB/GYN) beds in southeast Pennsylvania has decreased 28 percent, or one in four beds, since 1997.
- Although the Pennsylvania birth rate has remained stable in recent years, the percentage of low birth weight (2500 grams or less) babies needing more specialized care increased 15 percent from 1996 to 2004. In the southeast in 2006, NICU babies had an average hospital stay of nearly 15 days as compared to 2.8 days for babies not requiring intensive care.
- In all five southeast Pennsylvania counties the percentage of infants born at very low birth weight (less than 1500 grams) has risen (depending on the county, a 10-to-60-percent increase since 1998).
- Capacity and access issues affect the full continuum of maternity care, including the prenatal and postpartum services essential to assuring the best possible health outcomes for mothers and infants.

**Factors Contributing to the Crisis:** Low reimbursement, medical liability issues, workforce shortages, infrastructure limitations, and a culturally diverse patient population contribute to obstetrical capacity shortages and access issues.

- The disparity between reimbursements for obstetric services and the cost to provide them creates an ongoing challenge for hospitals. Medical Assistance (also called Medicaid), Pennsylvania's government-funded insurance for low-income residents, pays for one of every three births in the state and 40 percent of all births in the southeast. Unfortunately, Medical Assistance on average reimburses hospitals only 80 percent of their actual

inpatient costs and 54 percent of their outpatient costs. While OB reimbursement rates from commercial payors are better than Medical Assistance payments, they still fall far short of the level of reimbursement necessary to maintain financial viability. Inadequate insurance coverage for undocumented-immigrant, expectant mothers is also resulting in access and payment issues.

- The total cost of professional liability coverage for Pennsylvania hospitals has doubled since 2000, with obstetricians/gynecologists experiencing some of the largest increases. Since January 2003, nearly 70 percent of OB/GYNs have limited their practices or increased their use of “defensive medicine” (such as performing more cesareans) because of the lack of affordability or availability of professional liability insurance.
- Nearly a third of southeast Pennsylvania’s obstetricians/gynecologists have left the region or stopped practicing obstetrics since 2001.
- Based on their own monitoring of expectant mothers’ wait times for appointments and late entry into prenatal care, managed care companies share concerns regarding the adequacy of their provider networks for obstetrical services.

**The Impact on Patients:** The percentage of mothers beginning prenatal care in their first trimester has been dropping throughout the state and region, with Philadelphia having especially low rates. Because low-income, undocumented-immigrant expectant mothers become eligible for Medical Assistance only when they present for delivery, these women face greater challenges accessing the prenatal care essential to promoting healthy families. The rate of low and very low birth-weight infants is rising. The infant mortality rate in Philadelphia County is more than twice Pennsylvania’s Healthy People 2010 goal and approximately twice the rate of Montgomery County.

**Recommended Actions:** The OB Services Task Force’s 10-point action plan to maintain and improve access to OB services includes the following legislative, regulatory, operational and workforce recommendations.

- **Legislation to protect OB and maternity services** – To provide adequate hospital reimbursement for providers of obstetrical and neonatal services, legislation is needed to establish a disproportionate share payment for hospitals with a high proportion of Medical Assistance obstetrics patients.
- **Liability reform** – Reform is needed at the state and federal levels, including Mcare reform and continued abatement, joint and several liability reform, an administrative medical liability system demonstration (health courts), and the federal Healthy Mothers and Babies Act.
- **Regulatory flexibility for OB and NICU surge capacity** – The Pennsylvania Department of Health, which has regulatory oversight of obstetrical and neonatal intensive care units, should work with hospitals so they can develop the surge capacity needed to address increases in volume.

- **Elimination of duplicative city and state reporting requirements** –The development of a new module for the existing Pennsylvania Department of Health electronic birth certificate system will allow direct, electronic data transfer to the Philadelphia Department of Public Health, eliminating a duplicative reporting system.
- **Workforce development** – Qualifying communities may be able to improve their access to OB health professionals if they can achieve designation as Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas/Populations (MUA/Ps). In addition, encouraging workforce development organizations to increase their focus on obstetrical health care in existing regional career development initiatives will help ensure an adequate future workforce of OB health care professionals.
- **Promotion of cultural competency and workforce diversity** – The creation of a forum will encourage health care providers to share best practices related to building cultural competency in obstetric services and increasing diversity within the obstetric workforce.
- **Improved access to prenatal and postpartum care** – A model of care that uses midwives and nurse practitioners for normal pregnancy care and obstetricians for high-risk pregnancies will increase access to obstetric services.
- **Increased continuity between prenatal and delivery care** – Patient education, coordination with regional emergency medical services, and electronic medical records are needed to increase the percentage of expectant mothers receiving prenatal and labor/delivery care from the same physician/provider. Increasing delivering OBs' access to mother/infant medical histories will reduce the need for duplicative testing.
- **NICU capacity tracking** – A plan should be developed to create a real-time, NICU available-capacity website that would make use of the information technology infrastructure currently being developed as part of HAP/DVHC disaster preparedness activities.
- **Considerations for obstetric unit closures** – The development and implementation of best practices for the transition of patient populations when obstetrical units close will optimize continuity of care and minimize access issues.

**Conclusions:** Obstetrical services in the region and state are approaching a crisis situation. Since January 2007, four more hospitals (Excelsa Health's Latrobe Hospital, Monongahela Valley Hospital, Temple University Health System's Jeanes Hospital and University of Pittsburgh Medical Center's Greenville Hospital) have announced plans to close obstetrical units. Providing adequate access to appropriate prenatal, obstetrical, and postpartum care is essential to the health of mothers, their newborns, and the future of the Pennsylvania.

## Introduction

In response to mounting pressures on obstetric (OB) services in the southeast Pennsylvania (SEPA) region, due in part to the closing of thirteen OB units (Table 1.1) and a net loss of six neonatal intensive care units (NICUs) in the last decade (Table 1.2), the Delaware Valley Healthcare Council of the Hospital & Healthsystem Association of Pennsylvania (DVHC) held a region-wide OB services meeting on March 21, 2006, to begin a focused review of this critical service to determine whether there currently is adequate access to OB services, as well as how to address any future threats to accessing this service in the Delaware Valley. Ensuring access to appropriate prenatal, maternity and postpartum services is an essential investment in our region's future.

There is a concern that there are serious threats to, if not actual loss of, access to services for some populations and some communities in our region. There is a belief that intervention by hospitals to employ obstetricians, coupled with the action by the Governor and General Assembly to provide Mcare abatement, has prevented this situation from spiraling out of control. However, there are growing signs that the stop-gap efforts by both hospitals and government will no longer be sufficient to ensure widespread access to this crucial group of services. The situation demands action.

The March OB service meeting was attended by regional providers and other OB services stakeholders, including the Philadelphia, Montgomery County and Pennsylvania Departments of Health (PA DoH). A wide variety of concerns were identified (listed on page 6) that impact OB services in the region. In order to address these concerns, DVHC convened a Task Force comprised of a broad

**Table 1.1  
OB Units Closed in SEPA  
During the Last Decade**

<b>Hospital</b>	<b>Date</b>
Medical College*	1997
Nazareth	1998
Germantown*	1998
City Avenue*	1999
Roxborough	1999
Warminster	2000
Elkins Park*	2001
Episcopal*	2001
Mercy Philadelphia	2002
Methodist	2002
Mercy Fitzgerald	2003
Parkview*	2003
Frankford	2006

**Table 1.2  
NICU Changes in SEPA During  
the Last Decade**

<b>Units Closed</b>	<b>Units Opened</b>
Elkins Park *	Chestnut Hill
Episcopal*	Paoli
Mercy Fitz	Phoenixville
Frankford	
City Avenue*	
Methodist	
Montgomery	
Nazareth	
Medical College*	

\*Note: Where indicated, whole hospital closure or conversion to other uses resulted in loss of OB service or NICU.

set of stakeholders including providers, state and local health departments, consumer groups, and professional societies. The OB Services Task Force was charged with defining and examining the issues and challenges currently impacting the provision of OB services, with an emphasis on access and outcomes, and developing action steps to address identified concerns. The issues identified by the Task Force are multifaceted, ranging from payment and liability coverage to operational and data issues at the provider level. The actions necessary to address these issues similarly are complex, requiring action by all involved including providers, payors, government and patients. While the issues identified by the Task Force are not unique to southeast Pennsylvania, the magnitude of the problem is larger in this region as evidenced by the fact that in the last decade there have been 13 OB units closed in southeast Pennsylvania and a total of 33 OB units closed throughout the Commonwealth. A key challenge will be to build the necessary coalitions here in this region and with others across the Commonwealth to make meaningful progress on these systemic challenges.

### Reduction of OB Capacity

According to DVHC utilization reports, there has been a net decrease of 190 OB beds from 1995 to 2005. According to data from the Pennsylvania Department of Health (PA DoH), the number of licensed OB and obstetrical/gynecological (OB/GYN) beds in southeast Pennsylvania has decreased 28 percent from 1997 to 2005. In addition to the closing of 13 units, 13 additional units have reduced their OB bed complement. In order to absorb increased volume at remaining OB providers, nine OB units increased beds and two new OB units opened. Currently, there are 29 OB units serving the region, and as of fiscal year 2005, a combined total of 658 bassinets.

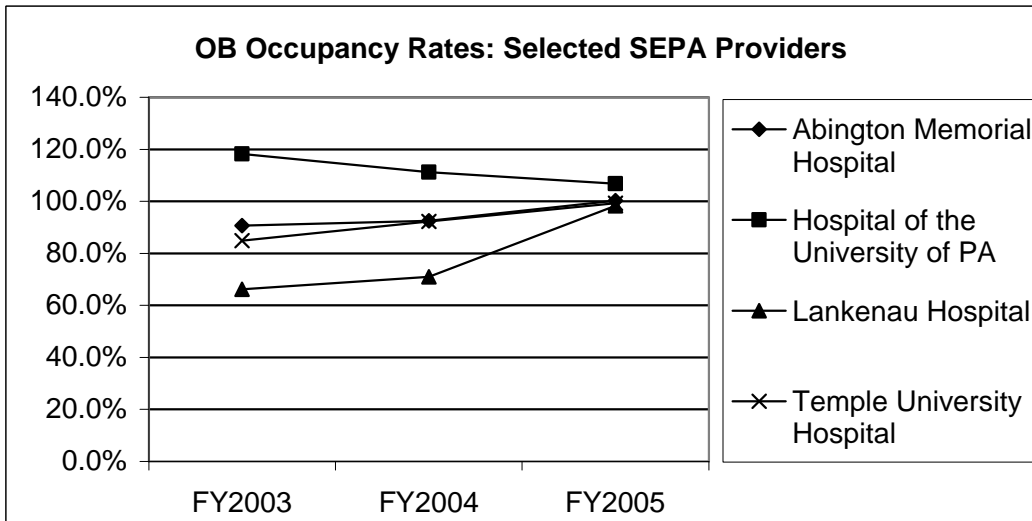
**Table 1.3**

<b>Pennsylvania Total Resident Births by County</b>									
<b>1998 through 2004</b>									
								<b>% Change</b>	
	<b>CY 1998</b>	<b>CY 1999</b>	<b>CY 2000</b>	<b>CY 2001</b>	<b>CY 2002</b>	<b>CY 2003</b>	<b>CY 2004</b>	<b>1998 to 2004</b>	<b>FY 2005</b>
Bucks	7,269	7,313	7,254	7,184	6,896	7,052	6,822	-6.1%	4,780
Chester	5,506	5,736	5,814	5,733	5,918	6,073	6,009	9.1%	5,513
Delaware	7,027	6,815	6,931	6,775	6,574	6,857	6,772	-3.6%	4,668
Montgomery	9,391	9,214	9,554	9,479	9,376	9,778	9,578	2.0%	13,444
Philadelphia	22,063	21,667	21,849	21,190	21,380	22,103	21,659	-1.8%	22,480
<b>SEPA</b>	51,256	50,745	51,402	50,361	50,144	51,863	50,840	-0.8%	50,885
<b>Pennsylvania</b>	145,606	144,828	145,874	143,404	142,380	145,485	144,194	-1.0%	131,486

Source: PA Department of Health

While births in the southeast Pennsylvania region are projected to decline 4.6 percent between 2005 and 2010<sup>1</sup>, as shown in Figure 1.1, several regional providers currently run consistently over 100 percent occupancy in their OB units. Overall, the projected reductions in births are offset by the recent decreases in capacity combined with changes in practice patterns, particularly increases in C-section rates that result in longer lengths of stay. As a result, an imbalance in capacity is being felt across the region.

**Figure 1.1**



It is also important to note that capacity and access issues in the region do not pertain solely to maternity units; they affect the full continuum of care. In order to assure positive birth outcomes for both mothers and infants, access to both prenatal and postpartum delivery services must also be addressed. Two major factors contributing to capacity shortage in these areas are workforce shortages and low reimbursement.

According to state Health Department data, since 2001 nearly a third of the region's OB/GYNs have left the region or stopped practicing obstetrics. Equally compelling, fewer and fewer physicians-in-training are choosing this specialty and of those that do virtually none are choosing to practice in southeast Pennsylvania. Hospitals report widespread difficulty in recruiting new OBs. Unfortunately this trend also extends to nurse midwives, who despite attending the highly regarded local programs choose not to stay here after completion of training.

**Major Issues Identified and Examined by the Task Force**

There are many factors contributing to this decline in OB capacity. In a recent provider survey conducted by DVHC, more than 70 percent of respondents indicated that there was a problem with access to OB services in the community that they serve. The major contributing factors include the high cost of medical liability coverage, combined with comparatively low reimbursement rates from

both public and private payors. These factors have jeopardized the financial viability of obstetrics units and negatively impacted recruitment and retention of obstetricians. In turn, in many areas of the region there are communities where expectant mothers face real challenges in accessing prenatal and obstetrical care services.

The major issues and threats to access identified by the Task Force are listed below.

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### **Quality Issues**

- Lack of timely access (prenatal, delivery and postpartum) for certain populations.
- Growing disparities in outcomes.
- Inadequate insurer/managed care provider networks for OB services.
- Growing workforce shortages (obstetrician, family practitioners, midwives, technicians, anesthesia, etc.).
- Inability to meet the unique needs of an increasingly diverse population.
- Need for greater collaboration among providers for changes in service capacity and unit closures.
- Lack of flexibility in NICU bed licensure to address surges in volume.
- Lack of coordination between prenatal care location and delivery location.
- Missed opportunities to support breast feeding to enhance outcome.

### **Financial Concerns**

- Inadequate reimbursement for OB/maternity services, including mandated testing and screening requirements.
- Inadequate insurance coverage (including meeting the needs of uninsured and/or undocumented mothers).
- Continuing impact of medical liability coverage crisis.
- Aging OB service infrastructure/high capital costs to increase capacity.

### **Information and Data Issues**

- Inability to track and manage NICU demand similar to emergency services.
  - Overly burdensome and duplicative city and state reporting requirements related to birth.
- 

In order to conduct more intensive reviews of these issues, the Task Force convened workgroups to examine reimbursement and liability, diversity and workforce, and data issues more closely. In addition to addressing factors related to the viability of the delivery system, an underlying premise of each work group's review was that recommendations should be designed from the perspective of consumers with the goal of improvement in access and reduction in treatment disparities. In addition to Task Force members, each of the work groups included participants with expertise in the areas addressed (Appendix B).

While the individual work groups were charged with addressing specific issues, there was a great deal of “cross fertilization” between the work groups as the discussions progressed. For example, the current liability coverage environment in the Commonwealth dramatically impacts providers’ ability to recruit physicians and midwives, increases practice costs, and therefore becomes a workforce and payment issue as well.

As part of this review, meetings were held with the PA DoH and the Pennsylvania Department of Public Welfare (DPW) to gain their perspective on these issues and discuss potential solutions.

## **Task Force Action Plan**

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As indicated above, the Task Force believes there is a need for immediate action to be taken to prevent further deterioration of this crucial service. The recommendations and action plan of the Task Force include budgetary, legislative, regulatory, and operational initiatives.

The Task Force’s recommendations can be summarized in a ten-point action plan:

### **Point 1: Enactment of Legislation to Protect Obstetrics Services**

- Seek legislation to assure adequate hospital reimbursement for providers of obstetrical and/or neonatal services through establishment of a disproportionate share payment for hospitals with a high proportion of Medical Assistance (MA)/Medicaid and uninsured obstetrics patients, similar in concept to an approach used for trauma centers and for burn facilities. This could lead to the enactment of an OB Services Stabilization Act.
- Seek legislation that would include provisions to meet the needs of undocumented immigrant mothers.
- Seek legislation to ensure the adequacy of managed care provider networks to meet patient access requirements.
- Seek legislation that would include funding for necessary facility/infrastructure upgrades.

### **Point 2: Liability Reform**

- Continue to advocate for specific tort reform for OBs, family practitioners that deliver babies, and certified nurse midwives, such as the Healthy Mothers and Babies Act at the federal level.
- Continue to work towards comprehensive Mcare reform and continued abatement, joint and several liability reform and an administrative medical liability system demonstration.

**Point 3: Improved Access to Prenatal and Postpartum Care**

- Develop a comprehensive plan for expanded prenatal care access to expand services with a proven track record to all pregnant women and encourage use of a model of care that uses midwives for normal pregnancy care and OBs for high-risk pregnancies.

**Point 4: Addressing the Issues of Key Caregivers**

- Conduct a review of Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA) designation possibilities for OB providers in southeast Pennsylvania.
- Explore partnerships in a collaborative manner with existing Federally Qualified Health Centers (FQHCs).
- Work in conjunction with the Life Sciences Career Alliance to establish targeted regional career pipeline initiatives to assure that an appropriate OB workforce exists.

**Point 5: Meeting the Needs of a Diverse Population**

- Create an ongoing regional committee which will serve as a forum for all southeast Pennsylvania OB service providers to identify community needs and share best practices (including language and related translation and signage) and develop cultural competency among providers (including development of a website to facilitate sharing of information).

**Point 6: Addressing the Disconnect Between Prenatal Care Location and Delivery Location**

- Until Electronic Medical Records (EMRs) become a reality, enhance current systems via patient education, issuance of cards provided to patients during their prenatal care that would include paramedic instruction regarding prenatal care location, and implementation of proposed Emergency Medical Services (EMS) maternity transport protocol.

**Point 7: Eliminating Duplicative City and State Reporting Requirements**

- Work with the PA DoH Statistical Registries to ensure that a new module is developed for the existing PA DoH electronic birth certificate system that would provide an electronic interface for data transfer to the Philadelphia Department of Public Health (PDPH).

**Point 8: Address Surge Capacity for NICUs**

- Work with the PA DoH to enable facilities to address surge capacity for NICUs.

**Point 9: Tracking NICU Capacity on a Real Time Basis**

- Develop a plan to interface the IT infrastructure currently being developed as part of Disaster Preparedness activities with regional NICU availability tracking.
- Develop a real time, NICU available-capacity website.

**Point 10: Considerations for OB Unit Closures**

- Ask hospitals to voluntarily adhere to best practices, including: adequate advance notice, especially to neighboring facilities who would likely absorb additional volume; transition plans for patients; and early involvement of key stakeholders.

The specific elements of the action plan follow.

**Enactment of Legislation to Protect Obstetrics Services**

**Issue:** Assuring Adequate Reimbursement for OB and Maternity Services, including Meeting the Needs of Uninsured/Indigent Mothers

**Background:** As previously noted, the Task Force found that the challenges affecting OB services providers are present throughout the 5-county region, though to varying degrees; some communities are already in a crisis, some feel that they are on the verge of a crisis, and some are currently managing reasonably well but see warning signs down the road.

Assuring the provision of quality and timely OB services to all pregnant women throughout the region is an investment in the future well-being of the children of the Commonwealth. It is important to assure that OB services are available within a reasonable proximity to the homes of pregnant women so that they are not forced to travel to other counties, or even other states, for prenatal care and/or delivery.

According to reports of key stakeholders, inadequate reimbursement for OB services coupled with increasing medical liability insurance costs is a strong contributing factor to the decline in numbers

<b>2005 Newborn and Neonate Payor Mix MA/Medicaid</b>	
<b>Patient County of Residence</b>	<b>Percent</b>
Bucks County	20.07%
Delaware County	27.29%
Chester County	20.68%
Montgomery County	17.52%
Philadelphia County	63.01%
SE PA	39.64%
All Other PA Counties	36.94%
Pennsylvania (All PA Residents)	37.91%
Total (incl. Non-PA Residents)	37.47%

Source: HAP Analysis of PHC4 CY 2005 MDC-15 Discharge Data.

of practicing OBs and the unit closures seen throughout the region over the past decade. In order to maintain and improve patient access, it is essential that steps be taken to assure the financial viability of the region's remaining practicing obstetricians and OB units in order to avert further closures. Since Medicaid payments comprise the coverage for a significant percentage of births in the region, as high as 63 percent in Philadelphia County, it is important to examine the adequacy of Medicaid payment rates.

Assuming that Mcare abatement or similar medical liability relief continues, the Task Force believes that Medicaid physician professional fees for delivery would need to approximately double, from the current Medicaid rates of \$1,200 for normal deliveries and \$1,500 for C-sections. Medicaid office visit rates, which currently average \$22 per visit, would need to quadruple. Furthermore, hospital Medicaid reimbursement rates for OB services would need to increase significantly over their current levels in order to cover operating costs, liability costs, and allow a modest margin to invest in capital improvements. Therefore, in addition to possible Medicaid rate increases, consideration should be given to accomplishing increased reimbursement under Medicaid through a creation of a special disproportionate share program to maximize use of federal resources. In order to provide the assistance needed by those providers currently in the midst of crises and prevent other providers from sliding into that state, the Task Force felt that, as was done for trauma services in 2003, it would be appropriate for legislative action to be taken at this time to stabilize OB services through the creation of the proposed OB Services Stabilization Act.

In addition, the Task Force believes there needs to be a mechanism to ensure an ongoing review of the adequacy of public and private payment rates for these services, such as an advisory panel convened by the DPW to review and recommend any adjustments to payment rates for OB/maternity services under Medicaid fee-for-service as well as HealthChoices. As part of this process, the advisory panel should develop a mechanism to compare those rates with the rates paid under private sector insurance plans and the relationship of payment rates to office practice costs.

The challenge of maintaining financial viability is faced by all OB service providers, regardless of payor mix. While OB reimbursement rates of commercial payors are more favorable than Medicaid payments, they still fall far short of the level of reimbursement necessary to maintain financial viability for OB services. Equally important, DVHC had an analysis done of payment rates to obstetricians in surrounding jurisdictions (e.g., NJ, DE, MD) which showed that commercial rates in southeast Pennsylvania for OBs are among the lowest reimbursement rates for non-employed independent physicians in the Mid-Atlantic region for both normal deliveries and C-sections (See Chart of Typical Regional OB Payments).

<b>Typical Regional OB Payments*</b>				
	<b>Normal Deliveries</b>	<b>% of Greater Philadelphia Medicare Rates</b>	<b>C-sections</b>	<b>% of Greater Philadelphia Medicare Rates</b>
Greater Philadelphia	\$2,085	100%	\$2,394	100%
Central Pennsylvania	\$2,512	120%	\$2,848	119%
Southern New Jersey	\$2,102	101%	\$2,581	108%
Delaware	\$2,382	114%	\$2,738	114%
Greater Baltimore	\$2,349	113%	\$2,662	111%

Source: DVHC 2005 Physician Reimbursement Report

Many providers continue to offer this service at a loss, because it is an essential part of their mission, but as we have seen in 13 cases over the past decade, many other providers have been forced to make the difficult decision to discontinue the service. However, it should also be noted that the larger forces impacting the overall delivery system have impacted this service as the closure of whole hospitals has resulted in nearly half of the OB unit closures in southeast Pennsylvania.

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\* The CPT Codes used in this study were based upon the frequency billed and were grouped by geographic category and represent the statistical mode for each geographic area. Payments included were from insurance companies only, exclusive of co-payment. This analysis was intended to be a directional study to provide insight into the proportional variances between payors within disciplines and within geographic areas. The data represented in this study is from independent physicians and not from physicians employed by a hospital or health system.

*Albert Einstein Medical Center and Temple University Hospital physicians have affiliation agreements with the City of Philadelphia's Department of Public Health (PDPH) to provide prenatal care at several PDPH neighborhood health centers to a patient population that includes a significant number of uninsured patients. However, the number of patients they can see at those locations are limited by workforce availability and the size of the facilities. Adequate funding levels in order to be able to justify continuation of services is also an issue.*

### **Meeting The Needs Of Uninsured/Indigent Mothers**

Since undocumented immigrants are not eligible for Medicaid until they present for delivery, there is an increased burden placed on hospitals, as well as greater risk of poorer outcomes, when these patients present with little or no prenatal care. Emergency Medicaid is by default the current source of funding for deliveries to undocumented mothers. The consequence is that often undocumented females present at the Emergency Department in labor

without adequate prenatal care, and hospital providers do not have any knowledge of their medical or prenatal history.

Philadelphia and Montgomery County Health Departments currently have programs to provide some financial support for care of undocumented immigrants and some providers contract with the city to provide care for the uninsured/undocumented at a global rate, independent of the number of deliveries. However, some providers have opted out of the program due to inadequate payment that does not cover the cost of services.

### **Unfunded Mandates**

Unfunded mandates also present a financial challenge to OB and NICU service providers. There are several screening tests that are done on newborns, either because they satisfy mandates, health department recommendations, or are part of current clinical standards, but which are currently not covered by either Medicaid or private payors.

In New Jersey, hearing screening and periodic monitoring is now a covered service under both the state Medicaid program and commercial payors and must be covered above and beyond the bundled rate. The justification for this is to "serve the public purposes of promoting the healthy development of children and reducing public expenditures for health care and special education and related services."<sup>2</sup>

## Investing in the Future

Another key to promoting healthy babies and reducing future health care expenditures is to encourage breastfeeding, since a breastfed infant is five times less likely to die before one year of age than a non-breastfed infant<sup>3</sup>. As shown below, infant death rates in the five southeast Pennsylvania counties significantly exceed the Healthy People 2010 goal, and while improvements

Infant death rate (under 1 year of age) (per 1,000 live births)						
COUNTY	2010 Goal	County 2000-04	County 1999-03	County 1998-02	County 1997-01	County 1996-00
Bucks	4.5	5.3	4.9	5.2	5.0	5.2
Chester	4.5	5.9	5.3	5.6	5.5	5.6
Delaware	4.5	7.1	6.6	6.4	5.9	6.1
Montgomery	4.5	5.5	5.6	5.4	5.6	5.7
Philadelphia	4.5	10.5	10.7	11.1	11.6	11.9
All PA Counties	4.5	7.2	7.2	7.2	7.2	7.3

Source: PA DoH Healthy People 2010

have been seen in some areas of the region over the past decade, the infant mortality rate in Philadelphia County is more than twice the Healthy People 2010

goal and approximately twice the rates of both Bucks and Montgomery counties (Chart on Infant Death Rate).

In addition, in the first year after birth non-breastfed infants are three times more likely to be hospitalized, two to seven times more likely to have allergies, over two times more likely to have type 1 diabetes, over two times more likely to have ear infections, two to five times more likely to have pneumonia, and two times more likely to die of Sudden Infant Death Syndrome (SIDS)<sup>4</sup>.

Since the availability of lactation consultants in the birth hospital has been shown to increase the rate at which new mothers initiate breastfeeding and in light of the above, reimbursement for lactation consultants prior to hospital discharge would be expected to be cost effective in the long run. The following Philadelphia hospitals provide lactation consultant services, though consultant availability varies from four hours per week to seven days per week for eight hours a day: Albert Einstein Medical Center, Chestnut Hill Hospital, Hahnemann University Hospital, Hospital of the University of Pennsylvania, Pennsylvania Hospital, and Thomas Jefferson University Hospital.

*Wide disparities currently exist for breastfeeding initiation rates. In Philadelphia, birth certificate data for 2004 shows the rate of breastfeeding for all races to be 40%. This includes, for White women a rate of 44%; for African-American women, 39%; for Hispanic women, 35%. This is a slight overall increase from 2003 when the rate of breastfeeding for all races was 39%; for White women, 43%; for African-American women, 37%; and for Hispanic women, 37%.*

**Recommendations:**

- Advocate for the enactment of an OB Services Stabilization Act, which would be legislation to improve hospital reimbursement for providers of obstetrical and/or neonatal services through establishment of a disproportionate share payment for hospitals with a high proportion of Medicaid and uninsured obstetrics patients, similar in concept to an approach used for trauma centers and for burn facilities.
- Phased-in increase of Medicaid fee-for-service payment rates for OB services over three years to achieve reimbursement levels commensurate with costs.
- A requirement that DPW include contract provisions mandating that Medicaid managed care rates for OB services are at least comparable to the enhanced fee-for-service rates.
- Formation of an OB/Maternity Services Payment Advisory Committee under DPW to review adequacy of Medicaid payment rates for these services and to report to the Secretary and General Assembly on an annual basis.
- Provisions to assure that current standard newborn testing requirements are funded, including those that are mandated, health department recommendations, and those that are done to meet current clinical standards, such as first trimester Down Syndrome screening, hearing screening, and cystic fibrosis screening.
- Establishment of a payment system for support services such as lactation consultants during inpatient treatment.
- Development of a plan for coverage of the full continuum of OB services, including prenatal and postpartum care, for undocumented immigrants.
- Reimbursement on an equivalent basis for innovative programs such as group model prenatal care.

**Issue:** Adequacy of Managed Care Provider Networks for OB/Maternity Services

**Background:**

During its review, the Task Force discovered that previously there were overlapping provider panels for OB/maternity services, but currently in certain sections of the region insufficient capacity exists. It is challenging to meet existing network sufficiency criteria, especially the requirements for appropriate language skills and the ability to provide timely appointments. Reportedly, managed care companies have acknowledged that they share the concerns regarding network insufficiency based on their own monitoring of waiting times for appointments and late entry into prenatal care. Temple University Physicians and the Maternity Care Coalition have each conducted studies of Medicaid managed care patient access based on phone surveys and found similar results. According to the Maternity Care Coalition study, within a five mile radius of the Norristown zip code 19401, 69 listed providers translated into only six who were actually practicing and accepting patients in that community<sup>5</sup>.

Efforts to improve the situation are underway, such as the DPW tracking outcomes for managed care contracts via the Health Plan Employer Data and Information Set (HEDIS) indicators during the current year, with plans to implement pay-per-performance in 2007.

**Recommendations:**

- Build on existing requirement that managed care plans demonstrate that their network has a sufficient number of providers actively accepting new patients by requiring PA DoH, as part of its quality assurance oversight role, to conduct quarterly reviews of Medicaid Managed Care participating OBs and granting PA DoH additional powers to enforce plan network sufficiency requirements. Network sufficiency standards should be specifically addressed in contractual agreements between managed care providers and the DPW.
- Require plans to demonstrate that managed care payments for OB services are adequate to attract and retain sufficient numbers of providers to provide enrollees with timely access to necessary OB services.
- Require validation of payment rates based on indices, such as rates in comparable urban areas.
- Assure that any Medicaid pay-for-performance proposal put forth by the DPW encourages adequate network coverage, prenatal care access, and recognizes the need for facility capital improvement.

**Issue:** Infrastructure upgrades/high capital costs to increase capacity

**Background:**

Many OB service providers in the region are dealing with aging and landlocked facilities at the same time that they are experiencing an increase in delivery volume. However, current reimbursement rates are not adequate to cover capital improvements. In addition, due to current guidelines regarding square footage requirements for new units, renovation would result in fewer beds in the same building space.

Infrastructure constraints are also an issue at the region's FQHCs, where extra capacity is needed to improve availability and timeliness of prenatal care. It has been reported that there have been occasions where obstetrical providers were on hand to care for patients at FQHCs, but were limited by inadequate space.

**Recommendation:**

- Develop comprehensive regional assessment of OB services capital infrastructure needs, to include both hospitals and other OB service providers, such as the region's FQHCs. This assessment should take into account appropriate national guidelines for maternity and NICU facilities.

# Liability Reform

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## Issue: Medical Liability Reform

### Background:

Medical liability costs currently contribute both to difficulty maintaining the financial viability of OB units and to recruiting and retaining practitioners, including both obstetricians and midwives. In addition, according to a survey conducted by DVHC earlier this year, over half of area hospitals responding now employ more than 80 percent of their obstetricians. Four others subsidize more than half of their independent OB physician liability coverage by including these physicians under the hospital policy. Some hospitals have even subsidized new practices to attract additional OB practices to their community.

In addition, access to OB services is limited by physicians opting to only provide gynecology services, due to the high cost of obstetrical medical liability insurance.

The total cost (primary premiums, Mcare assessment, and excess premiums) of medical liability insurance coverage for Pennsylvania's hospitals has stabilized, but remains 93 percent higher than in 2000. While the extension of the Mcare abatement program through 2007 is a positive step in the short-term, it ultimately does not decrease the underlying cost of coverage or achieve long-term reform.

*The costs of maintaining medical liability coverage have been a strong contributing factor to OB unit closures; a southeast Pennsylvania hospital with a net patient revenue of approximately \$116,000,000 a year realized a \$3 million, or 30%, reduction in the hospital's total medical liability costs subsequent to closure of their OB unit, decreasing their liability expense from approximately \$9 million to \$6 million annually.*

According to a HAP survey conducted in September 2006, four out of five hospitals report that some of their affiliated physicians have stopped practicing within the last five years, medical residents are more likely to choose permanent practice sites outside of Pennsylvania, and recruitment of new physicians to the Commonwealth is increasingly more challenging. Obstetrics is among the specialties most dramatically affected by these trends.

### Recent Legislative Efforts

Recent legislative efforts to address liability concerns specific to OB services include, at the federal level, S. 23: Healthy Mothers and Healthy Babies Act introduced by Senator Santorum in the spring of 2006. Provisions of this bill included:

- Institution of a \$750,000 stacked cap on non-economic damages, including a \$250,000 limit on the non-economic damages assumed by health care providers.

- Establishing a reduced statute of limitations (current tail 21 years).

### **Administrative Medical Liability Systems**

Senate Bill 1231, sponsored by Senator Jane Orie, would authorize the establishment of a demonstration program to examine an administrative medical liability system in Pennsylvania. HAP worked with Common Good on the development of this legislation.

Administrative medical liability systems, also known as health courts or special courts to handle medical injury cases, offer many potential benefits. A proposal for health courts has been developed by the nonprofit group Common Good and the Harvard School of Public Health, with the support of the Robert Wood Johnson Foundation.<sup>6</sup> According to their proposal, health courts would include the following:

- Trained judges with expertise in health care.
- Neutral experts retained by the court to assist the judges in making decisions about the standard of care.
- A schedule for awarding non-economic damages based on patient circumstances and severity of injury.
- Strong linkages to patient safety and quality improvement initiatives.

Health courts would employ a standard of liability known as avoidance, rather than negligence; that is, an injury would be deemed compensable if it could have been prevented or “avoided” had best practices been followed. The system would also promote equity through the use of compensation schedules for non-economic awards based on patient circumstances and severity of injury and would have strong linkages to patient-safety structures.

### **Recommendations:**

- Continue advocating for specific tort reform for OBs and Certified Nurse Midwives, such as the Healthy Mothers and Babies Act at the federal level, and the Fair Share Act and the Administrative Medical Liability System Demonstration Act at the state level.
- Further work towards comprehensive Mcare reform (abatement, long term phase-out of Mcare program and retirement of unfunded liability).

The Task Force understands that medical liability reform is an ongoing statewide priority. The potential recommendations outlined above will also be forwarded to the HAP Liability Reform Task Force for review and inclusion in the overall hospital association statewide agenda for liability reform.

## Access to Prenatal and Postpartum Care

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**Issue:** Assuring timely access (prenatal and postpartum)

**Background:**

Access has been identified as a concern throughout the region, especially for low-income, uninsured and undocumented immigrant patients. Assuring high quality and timely access for all pregnant women in the region is the underlying primary objective of the Task Force. As shown below, there is significant variation in the percentage of births to mothers beginning prenatal care in their first trimester, and the region as a whole falls short of the Healthy People 2010 goal of 90 percent throughout the region, with Philadelphia County having especially low rates.

% live births to mothers beginning prenatal care in first trimester						
COUNTY	2010 Goal	County 2002-04	County 2001-03	County 2000-02	County 1999-01	County 1998-00
Bucks	90	87.9	90.2	91.6	91.7	91.7
Chester	90	84.7	86.3	87.2	88.1	87.6
Delaware	90	82.0	84.3	86.1	87.0	86.9
Montgomery	90	86.9	88.1	89.5	89.9	90.0
Philadelphia	90	68.4	71.0	73.6	74.4	74.5
All PA Counties	90	82.7	84.0	85.1	85.3	85.1

Source: PA DoH, Healthy People 2010

Services with a proven track record for improving outcomes, such as those provided under Healthy Start, Nurse/Family Partnership and Healthy Beginnings Plus, currently do not have sufficient funding to allow the programs to serve all who could benefit from them. In addition, Healthy Start is a federal program with very stringent eligibility guidelines, whereby only residents of areas with extremely poor infant mortality rates, 1.5 - 2.5 times the national average, are eligible to participate. The Nurse Family Partnership is a state funded program that utilizes RNs to provide home visits to low-income, high-risk pregnant women, but is limited by a shortage of RNs to staff the program. Healthy Beginnings Plus is a state program whereby providers meeting specified criteria for a higher standard of care are eligible for an enhanced reimbursement rate under fee-for-service Medicaid.

Other factors are also impacting access to prenatal care. For example, the Norristown FQHC stopped providing prenatal care in December 2005, and hospital clinics have been overwhelmed. In Chester County, there is only one hospital-based prenatal care clinic in the county. As a result, women from communities outside that provider's usual service area are traveling to this

location. The clinic sees a large proportion of undocumented Latino women. They offer a prenatal care package plan that women have to pay for out-of-pocket.

*In Chester County, immigrant growth has been very rapid in the last few years and has been accompanied by increasing birth rates. The Latino population in the county increased 86% between 1990 and 2000. Since 2000, the number of births to Latino women has surpassed the number of births to African American women, although there are twice as many African American women in the county. Currently, 82% of new enrollees in the Chester County Healthy Start program participants are uninsured and 60% are undocumented immigrants*

*In the midst of these changes, the program, which serves 1,200 women and 900 infants annually, has achieved Healthy People 2010 outcomes objectives for African American and Latino participants. Community outreach has proved to be invaluable to achieving these results and also creating community buy-in. In addition to outreach, the program offers case management, depression screening, medical interpreting (in which they also offer training), the county's only Spanish language prenatal and parenting classes, and cultural competency training to expand the capacity of OB services to work with diverse populations. The program also screens participants for health insurance status and assists them with MA and CHIP applications. In 2005, the program was successful in obtaining MA coverage for 99% of uninsured enrollees.*

*Despite the impressive results of this program, significant challenges remain in the county, as in the rest of the region. For example, private practitioners have a large unmet need for medical translation services, in part due to cost. Studies have shown lack of translation services tend to impact prenatal care access, quality and safety.*

### **Programs Developed to Improve Access**

In order to fill the gap in prenatal care services, some teaching hospitals offer open access prenatal care using a residency program model of care and substantially funding the program themselves.

In an effort to provide optimal prenatal care to low-income women with little existing social support, a group model pilot project was conducted in North Philadelphia as a feasibility study to determine whether an alternative delivery method, such as centering pregnancy care (a model of health care delivery that integrates the provision of health assessment, education, and support within a stable group of women, families/ friends, and babies) would be effective in improving outcomes for this population. The program utilized a combination of group instruction and individual services, both provided by a nurse midwife. Feedback from participants regarding the program has been very positive and seven out of eight participants completed the program and delivered healthy full-term babies. In addition to enhancing the support system of the women, the health education aspect of the program was felt to be especially effective in the group setting, as it enabled participants to both support and learn from one another's questions and concerns.

Another alternative model program in the region that utilizes peer-to-peer support is the MOMobile offered by the Maternity Care Coalition that uses community health workers to provide community-based outreach in high-risk neighborhoods and support to pregnant women, linking them to prenatal care, pediatric and women's health care, behavioral health services, nutrition programs and other education in eight southeast Pennsylvania communities.

### **Essential Elements to Improve Access and Outcomes**

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- Increased number of providers serving the Medicaid patient population.
  - Community-based programs to identify those needing prenatal care services and including advisory groups which are representative of the community.
  - Medical interpreting, including skills assessment and training and cultural competency training.
  - Enhanced outreach and education to women regarding care options in a manner that translates into women really understanding how to access needed care and utilizing community resources, such as schools.
  - Case management for high-risk mothers.
  - Smoking cessation.
  - Depression screening.
  - Seamless linkage to any necessary behavioral health services.
  - Screening participants for health insurance status and assisting them with Medicaid and Children's Health Insurance Program (CHIP) applications.
  - Transportation to services and programs.
- 

In addition to improving prenatal care access, achieving positive birth outcomes and improving the health of pregnant women would be aided by increasing the length of Medicaid postpartum care eligibility in order for interconceptional care to be covered, which would be expected to increase the percentage of planned pregnancies and allow a variety of risk factors to be addressed before conception in order to reduce the risk of adverse outcomes for both the mother and the infant<sup>7</sup>. The PA DPW is currently looking at expanding postpartum coverage from 60 days to six months, which would be a great improvement. However, the literature has shown that an interpregnancy interval of 18 months improves outcomes, and the Task Force has recommended expanding coverage to two years postpartum.

Also important is providing seamless linkages to behavioral health services. A study conducted by Rand Health to develop a blueprint for improving maternal and child health care in the Pittsburgh region included family behavioral health in their top four priorities for improvement<sup>8</sup> along with a recommendation for Medicaid managed care contracts to support collaboration between physical health managed care organizations and behavioral health organizations<sup>9</sup>.

Providing seamless linkages between OB services and behavioral services and programs for drug-addicted pregnant women would, in addition to generally

enhancing quality of care, also potentially result in reduced future NICU costs post-delivery. Reportedly, some providers have opted to provide free prenatal care to this population in order to avoid costly NICU admissions.

**Recommendations:**

- Develop comprehensive plan for expanded prenatal care access, to include an increase in federal and state funding of existing prenatal care services sufficient to meet the Healthy Beginnings Plus standards and development of a vehicle to expand services proven to have a positive impact on outcomes to all eligible families.
- Encourage the use of a model of care that uses midwives and nurse practitioners for prenatal care and normal pregnancy care and obstetricians for high-risk pregnancies.
- Develop region-wide mechanism to track patients with no prenatal care/unregistered patients.
- Expand maternal Medicaid coverage for two years after delivery in order to provide interconceptional care, and preventive care per 2006 Centers for Disease Control and Prevention (CDC) guidelines, unless other coverage is obtained.
- Structure Medicaid managed care contracts to support collaboration between physical health managed care organizations and behavioral health organizations and related data analysis to show offset in NICU costs.
- Facilitate Medicaid enrollment via expanded outreach and education efforts to uninsured women prior to and during pregnancy and an enhanced match for administrative services/outposting eligibility and enrollment staff to clinics.
- Develop mechanism to coordinate public and private interventions in selected target areas of highest need, i.e., areas with high infant mortality rates.

## Workforce and Diversity

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Assuring an adequate workforce and meeting the needs of an increasingly diverse population are also essential to providing access and quality services in the region. Providers are currently struggling to increase overall numbers of OB providers and diversity throughout the professions. At the same time, providing culturally competent care, including meeting the language needs of patients, is essential to providing high quality and accessible care. The Task Force realizes that workforce shortages are a statewide issue and must ultimately be addressed as such.

**Issue:** Assuring adequate workforce (obstetricians, family practitioners, midwives, lactation consultants, technicians, anesthesia, etc.)

**Background:**

As shown below, the number of OB/GYNs in southeast Pennsylvania decreased 27 percent between 1997 and 2004.

<b>SEPA OB/GYNs</b>			
	1997	2004	Change
Bucks	66	61	-5
Chester	63	56	-7
Dela	92	64	-28
Mont	230	207	-23
Phila	542	335	-207
Region	993	723	-270
State	2010	1742	-268

Source: Pennsylvania Department of Health

In addition, only 68 percent of physicians who work in obstetrics/gynecology as their primary field of practice indicated that they currently deliver babies, 12 percent of physicians who work in a family practice and currently deliver babies indicated that they plan to stop doing so within the next 12 months, and seven percent of physicians who work in obstetrics/gynecology and currently deliver babies indicated that they plan to stop doing so within the next 12 months<sup>10</sup>.

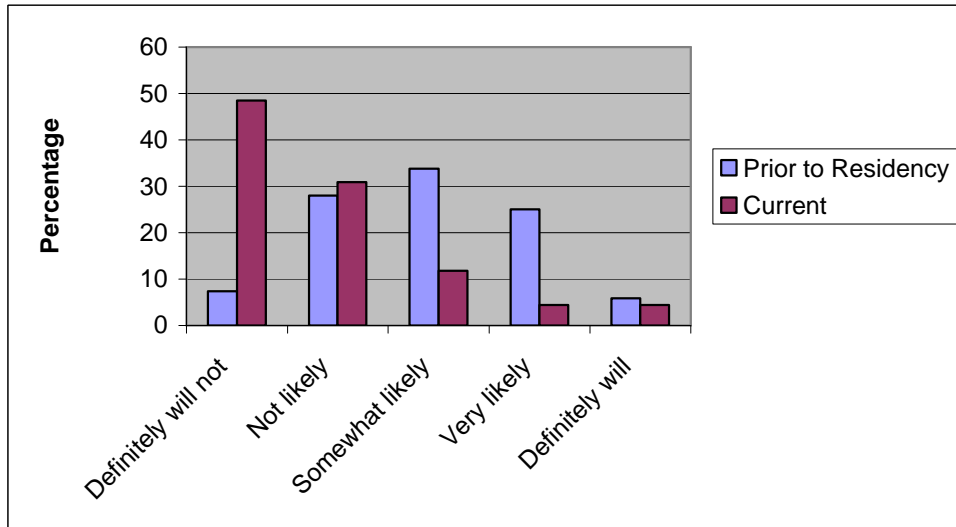
It is noteworthy that most of the remaining regional OB providers have or are affiliated with OB residency programs, which enables them to use a resident model of care and also helps in justifying continuation of the service. However, there are proposed cuts in governmental funding for residency programs which could threaten the feasibility of maintaining this program. In addition, retaining newly trained OBs in the region is increasingly difficult.

**Workforce Shortage**

A study by researchers at the Department of Health Policy and Management of the Harvard School of Public Health looked at the impact of malpractice insurance costs on residents' decision whether to remain in Pennsylvania to practice after completion of their training. As shown in Figure 1.2, the percentage planning to remain shifted dramatically from the data collected prior to their residency to the time of completion<sup>11</sup>. Of those unlikely to stay,

65 percent indicated that the cost of malpractice insurance was a significant factor in their decision.

**Figure 1.2 Percentage of Residents Planning to Practice in Pennsylvania After Completion of Training**



Source: Mello. Effects of Professional Liability Crisis on Residents. *Obstet Gynecol*, 2005.

One way to expand the pool of OB providers is to maximize the use of the full continuum of qualified providers, including obstetricians, family practitioners, midwives, physician assistants, and doulas. The National Institute of Medicine has recommended increased use of nurse midwives for the delivery of women’s health care<sup>12</sup>. In an effort to expand the role of certified nurse midwives (CNMs), the PA DoH is working on expanding nurse midwives’ privileges to put them on par with the privileges of nurse practitioners. However, efforts to increase utilization of CNMs for OB services are limited, in part, by the small number currently practicing in the commonwealth. Based on the 2004 Bureau of Professional and Occupational Affairs re-licensure survey, there were approximately 420 practicing CNMs in Pennsylvania, including 15 in Bucks County, 12 in Chester County, 15 in Delaware County, 34 in Montgomery County, and 51 in Philadelphia County.

Another provider extender option for maternity care would be increased use of doulas, who are trained to provide labor support, thus enabling OBs to care for increased numbers of maternity cases. In addition, one-on-one support of laboring women by either a nurse, nurse-midwife, or doula is the only intervention that has consistently been shown to reduce cesarean delivery rates<sup>13</sup>. Assuring that training programs for family practitioners fully prepare them to handle OB cases would also be of value.

## **Increasing Diversity Throughout The Professions**

Increasing diversity throughout the professions and workforce development that reflects the workforce of the future is also essential, since under-represented minorities (URMs) are more likely to practice in under-served areas and in settings, such as clinics, where the under-served often receive care<sup>14</sup>. In addition, URM providers often choose to practice in specialties that are very badly needed, such as primary care, and studies have also shown that people are more likely to see a doctor of their own race.

One way of improving the number of URMs in the workforce is with targeted career pipeline initiatives. The southeast Pennsylvania Area Health Education Center (AHEC) supports several health career programs in the five county region; nearly all are within high schools with high minority populations. One program which the AHEC has partially supported since 1998 is the Physician Scientist Training Program (PSTP), previously the Minority Access to Research Careers program. The program is highly competitive and is sponsored by and

*At Temple University Health System a program has been implemented that provides programs on site at North Philadelphia schools to promote health professional awareness and engages medical students as mentors, offers Saturday academies at the Health Sciences Center that include both lectures and hands-on activities, and a summer program to help local students prepare for the MCATs. Despite its encouraging results, maintaining funding is an issue as Title VII funds have been cut.*

delivered at Temple University in a six week period where students attend sessions five days per week. In 2006, the reported retention rate of the PSTP students from seventh grade through college is 90 percent. In September 2004, 19 trainees matriculated into medical and graduate schools.

## **Underserved Area Designation**

Shortage designation ultimately falls under the purview of the Shortage Designation Branch of the Health Resources and Services Administration Bureau of Health Professions National Center for Health Workforce Analysis. The PA DoH Bureau of Health Planning provides technical assistance to applicants within the Commonwealth and serves as a link between applicants and the Shortage Designation Branch.

Health Professional Shortage Area (HPSA) designation is available for areas or populations with shortages of primary care physicians, dentists, and mental health professionals. Eligibility for designation is based on the ratio of population to providers in an area. Designation as a MUA or Medically Underserved Population (MUP) is based on an evaluation of the percentage of persons in poverty, percentage of elderly, infant mortality rate, and provider-to-population ratios. Area designations may be a whole county or group of contiguous counties, minor civil divisions, or census tracts. Population designations may

include groups of persons who face economic, cultural, or linguistic barriers to health care<sup>15</sup>.

Additional workforce shortage area designation in the region may facilitate recruitment of obstetricians who have recently completed their training and need to fulfill loan obligations related to working in designated areas and qualify for the increasingly competitive National Health Service Corps or PA loan repayment programs. Forming partnerships between hospitals and existing FQHCs would also aid in this effort, since they are automatically deemed as having HPSA facility designation. Forming successful partnerships between providers and FQHCs requires addressing related legal and operational issues, such as assuring that health center providers have necessary privileges at the partner hospital and that medical record information is transferred in a timely manner to assure seamless continuity of care.

HPSA and MUA designation offer many benefits; however, qualifying can be a challenge even for areas where a shortage of OB providers is evident. In part, this is due to the fact that obstetricians are included in the primary care provider category of the physician survey component of the screening process. As a result, there may be a shortage of physicians who provide prenatal care and deliver babies, but the area may not qualify. Another issue is that the screening process also takes into consideration provider numbers in contiguous areas, so that an underserved area located contiguously to a medical center may also not qualify.

Preliminary analysis of the southeast Pennsylvania region shows that a significant number of areas might be eligible for MUA designation based on the first three variables included in the Index of Medical Underservice:

1. Percentage of the population below the poverty level, 2. Infant mortality rate, and 3. Percentage of the population over 65. However, each area would also need to be surveyed to determine the ratio of primary care providers to population, which would then eliminate more from eligibility, especially since there is not a separate category for obstetricians.

**Recommendations:**

- Conduct a collaborative review of HPSA and/or MUA designation for OB providers in southeast Pennsylvania. If necessary, pursue legislation to make it easier for the region to qualify for underserved area designation by removing obstetrics from the primary care designation.
- Explore partnerships in a collaborative manner with existing FQHCs to facilitate recruitment of obstetricians who have recently completed their training and need to fulfill loan obligations.
- Work in conjunction with the Life Sciences Career Alliance to establish targeted regional career pipeline initiatives to assure that an appropriate OB workforce exists to meet the needs of southeast Pennsylvania communities.

**Issue:** Meeting the needs of an increasingly diverse population

**Background:**

The region currently faces significant challenges in meeting the needs of an increasingly diverse population. Many hospitals and health systems have already invested in learning about their diverse communities and have trained staff, added multi-language signage, etc. The Chester County Hospital has convened a task force on cultural competency and DVHC has a cultural competency initiative that included a symposium on cultural diversity and a series of workshops in 2005, to improve communication and provide opportunities to share ideas and resources among hospitals. The workshops included training on cultural competency and a review of the National Standards on Culturally and Linguistically Appropriate Services (CLAS), which recommend that health care organizations develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities<sup>16</sup>. In addition, an assessment tool for hospitals to use in evaluating their current level of cultural competency was developed as part of the initiatives.

In addition to developing a diverse staff, as described above, the importance of cultural competency training is now widely recognized and is coming to the fore with organizations such as The Joint Commission. As a result, a variety of resources are being developed at both the state and national level, for example, by the Pennsylvania Medical Society and the American Medical Association. Some of these resources have been developed for physician education but could be adapted for training others, as well. The Task Force felt there would be a benefit to creating a forum to link resources with those who are interested in and could benefit from using them. Therefore, the recommendations below seek to bridge this gap.

**Recommendation:**

- Create an ongoing regional committee which will serve as a forum for all southeast Pennsylvania OB service providers to identify community needs and share best practices (including language and related translation and signage) and develop cultural competency among providers in adherence with the National Standards for CLAS developed by the US

*Springfield Hospital of the Crozer-Keystone Health System conducts a biennial assessment, using Philadelphia Health Management Corporation (PHMC), targeting specific areas to assess needs and develop responsive programs. Specific indicators are also developed to measure program effectiveness. The hospital currently serves patients speaking 81 languages.*

Department of Health and Human Services, Office of Minority Health. This committee would be informed by a broadly representative cultural diversity advisory committee. As part of this initiative, consider the development of a website to facilitate sharing of information.

## Regulatory Issues

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**Issue:** Address Surge Capacity for NICUs

**Background:**

The closure of several OB and neonatal intensive care units (NICUs) in the Philadelphia area over the last decade has resulted in increased volumes at the remaining providers, often with little or no advance notice. As a result, the hospitals absorbing the displaced volume have not had sufficient lead time to make the infrastructure changes that would be necessary to remain in compliance with existing licensing regulations. In addition, current reimbursement levels make it difficult to afford expansion of OB and neonatal intensive care units. The current guidelines also include increased square footage requirements, which result in fewer beds/bassinets in a given space, and would therefore put many providers further out of compliance post-renovation, especially those in inner city locations.

Even without the challenges presented by the recent unit closures, patient volume in NICUs is variable and not easily controlled, as it is impacted by several factors not under the control of NICU staff, including delivery volume, variable acuity of cases, and the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements that providers use to evaluate all presenting patients. As a result of the above, there are periods of time when NICUs are, out of necessity, providing care for neonates with provision of notification to the PA DoH.

<b>% of infants born at very low birth weight (VLBW: less than 1500 grams)</b>						
	2010	County	County	County	County	County
COUNTY	Goal	2002-04	2001-03	2000-02	1999-01	1998-00
Bucks	0.9	1.5	1.3	1.3	1.3	1.4
Chester	0.9	1.8	1.3	1.3	1.2	1.1
Delaware	0.9	2.1	1.6	1.6	1.6	1.6
Montgomery	0.9	1.6	1.4	1.3	1.3	1.3
Philadelphia	0.9	2.8	2.5	2.4	2.4	2.5
All PA Counties	0.9	1.8	1.6	1.6	1.5	1.6

Source: PA DoH Health People 2010

Patient safety and quality of care are of the utmost importance and it is often not in the patient's best interest to be transferred to another NICU, unless the appropriate level of care does not exist at the facility of birth. In particular, transport of tiny preterm neonates of <1500 grams birthweight is known to result in sub-optimal medical outcomes. As shown above, the percentage of births in this category has increased over the past decade, with Philadelphia's rate notably higher than the rest of the region and the Commonwealth as a whole. In addition, the transfer of neonates often creates hardship for the parents and other family members who wish to visit the infant.

**Recommendations:**

Hospitals must be enabled by PA DoH to address surges in NICU volume, based on the following criteria:

- It would be the responsibility of the provider to demonstrate:
  1. Compliance with the Guidelines for Perinatal Care<sup>†</sup>, based on the complement of patients, acuity levels, staffing, and appropriate headwall space.
  2. Adequately equipped headwall (oxygen, suction, electrical outlets) to assure the safety and highest quality of care for the current patient population (i.e. two level 2 infants can share 1 level 3 bay).
- Monitor NICU capacity by tracking the average daily nursing hours/patient day and occupancy rates of:
  1. Certified bassinets
  2. Staffed bassinets
- Address regulations that prohibit transfer from a licensed to an unlicensed bed and prevent the movement of babies who no longer need NICU level care to a well-baby setting.

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<sup>†</sup> With the exception of current square footage requirements; it would be important for existing beds be grandfathered in, so that units can maintain existing beds in the same footprint.

## Operational and Data Issues

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**Issue:** Need to address disconnect between prenatal care location and delivery location

**Background:**

Comprehensive implementation of electronic medical records (EMRs) throughout the region would help to alleviate other issues identified by the Task Force, such as the negative impact on patient care when women present at the time of delivery at a hospital other than the one where they received their prenatal care, thus necessitating all to be treated as high risk since their medical records, including pre-admission testing results, are not available. However, until EMR becomes a reality, alternatives are needed. While the disconnect between prenatal care location and delivery location is not always due to emergency medical services (EMS) transport, it was felt that enhancing the current system would be valuable and the following draft protocol was developed.

Patient education would be the key component of the protocol to assure that patients being transported via ambulance at the time of delivery are taken to the hospital where they received their prenatal care, reinforced and supported by cards, such as those provided by the Hospital of the University of Pennsylvania OB service to patients during their prenatal care that would include paramedic instruction. The cards would include contact information for the patient's obstetrician and/or midwife, hospital where prenatal care was received, and phone number of that hospital's ambulance service.

**Recommendations:**

The Task Force recommends implementation of the following proposed protocol:

- Prenatal care service providers include education on accessing services when going into labor and develop a maternity care transport card for distribution to all pregnant women under their care.
- In cases where a patient is registered at a hospital with its own or a contracted ambulance service, instruct patients to call that ambulance service if necessary when they go into labor.
- In cases where it is a medical emergency, instruct the patient to call 911 and to present their maternity transport information card to the paramedics. If medically appropriate and feasible, the patient would be taken to the hospital where prenatal care was received, especially if the transport time is no more than 15 minutes greater than it would be if they went to the closest hospital. Unless critical, maternity patients would be taken to a hospital with an OB service to avoid having to be transported

again. In truly emergent cases, the current EMS guidelines would apply and the patient would be transported to the closest hospital.

- In a limited number of the most critical cases, utilize the computer-aided dispatch (CAD) program “premise history” to link maternity patients to the hospital where registered, as is sometimes done for disabled and elderly patients, on a case by case basis for high risk patients, such as preterm labor and those currently being treated for specific medical problems such as hypertension, previously diagnosed fetal anomalies, intrauterine growth restriction, or any specific issue where a plan has been put in place other than routine care. For these cases, the name of the specialty hospital would be added to the card, along with any other necessary medical contact information and a brief description of the condition. There also would need to be a process to terminate the special “premise history” from the CAD system upon delivery/resolution of the situation. Also, eligible patients would need to be educated that this system functions based on address rather than name.

**Issue:** Regional Tracking System to Manage NICU Demand

**Background:**

The closure of OB units in the region has also resulted in multiple NICU closures. As a result, NICU services have consolidated, remaining units are overburdened, and, as was previously described, volume at times exceeds capacity and available resources. Therefore, there would be a significant benefit to providers knowing where capacity exists in the region on a real time basis when transfers are necessary.

**Table 1.4 Recommended Metrics**

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**Neonatal Demand**

Utilization by birth weight category

Mortality rates by birth weight category

**Number of mothers transferred due to inadequate maternal beds**

Transfers from other facilities

Transfers to other facilities

**Number of mothers transferred due to inadequate neonatal beds**

Transfers from other facilities

Transfers to other facilities

**Number of babies transferred due to inadequate capacity or staffing**

Transfers from other facilities

Transfers to other facilities

**Number of babies cared for in excess of licensed/staffed beds**

**Patients with no prenatal care/unregistered patients region-wide**

**Number of non-emergent cases utilizing 911 at time of delivery**

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Table 1.4 shows recommended statistical indicators to inform the development of a NICU tracking system, as well as to quantify the magnitude of the disconnect between prenatal care and delivery location.

**Recommendations:**

- Develop a plan to interface the IT infrastructure currently being developed as part of Disaster Preparedness activities with regional NICU availability tracking.
- Develop electronic survey instrument for regional OB service providers using proposed metrics to give a snapshot of the current state of OB and NICU services and initiate pilot six month data collection effort to evaluate the utility of a regional NICU tracking system prior to development of such a system.
- Development of real time NICU available capacity website.

**Issue:** Duplicative City and State Reporting Requirements

**Background:**

The Philadelphia Department of Public Health (PDPH) has programmatic needs for birth information within a shorter timeframe than is currently available from the state electronic birth certificate database, in part due to the current reporting timeframes of some providers. While the information required by the PDPH would be available immediately upon the birth of the child, many other elements are not available until discharge, which is one reason submission is delayed (time required to extract data elements from charts is another). Therefore, the Philadelphia Department of Public Health initiated a process to respond to the Philadelphia Board of Health regulation requiring notification of births within 24 hours, resulting in duplicate reporting requirements for Philadelphia hospitals. In order to address this, meetings were held with representatives of the Bureau of Health Statistics and Research, the PDPH, and hospital representatives to explore other options.

Based on discussions with the Task Force, the Bureau of Health Statistics and Research has proposed development of a new module that would provide an electronic interface to allow the data required by the Philadelphia Department of Public Health to be transferred to them by providers, and this could be implemented relatively quickly. The electronic birth certificate was originally designed to accommodate a two-step process, where initial basic information could be submitted and a file number remitted to the provider, allowing the provider to complete the record at a later date. Utilizing this function, with minor revisions to the software, would allow the data required by the Philadelphia Department of Public Health, which is a subset of the electronic birth certificate, to be submitted within the 24 hours required by the Philadelphia Board of Health mandate and the remainder of the information required to complete the electronic birth certificate to be submitted within the 10 days required by the PA

DoH. In addition to eliminating the duplicate reporting of this data, this system would provide a cross-check for each birth certificate record. It would also be highly desirable to have linked computer terminals available on the OB units.

In the long term, the Task Force recommends that a web-based system be developed that would allow data elements to be input to the record as soon as available, and that output of the system be made available to those requiring it, such as the Philadelphia Department of Public Health, on a real time basis. There is a precedent for this for other health record reporting, such as the Philadelphia Department of Public Health immunization reporting.

**Recommendations:**

- Development of a new electronic birth certificate module that would provide an electronic interface for data transfer.
- Upgrade of provider reporting systems so that data submission meets necessary city and state submission timeframes.
- Development of a uniform, single-submission reporting system that serves the needs of both city and state agencies and eliminates burdensome duplicate reporting requirements for providers, including development of a realtime submission system, necessary software development and hardware upgrades. As part of the process, review data elements and work with providers to ensure timely submission of data into the uniform systems.

**Issue:** Considerations for OB unit closures

**Background:**

One of the questions raised in response to the closure of OB units in the region is whether or not guidelines for closure need to be established. In order to address this question, the Task Force examined the experience of providers who had closed an OB service, as well as its impact on the remaining OB units who have absorbed additional patients into their service as a result of another hospital's closure. As a result of these discussions, it was determined that maintaining quality and continuity of care is the key issue, rather than the specific length of time required to accomplish that outcome. Allowing sufficient time for patients to plan and facilities that will be receiving additional patients to make necessary adjustments in staffing and infrastructure is critical, especially in areas where multiple closures in close proximity have put increasing demands on the remaining providers.

Communicating with neighboring hospitals is especially important in order to assure a smooth transition of patients to a new health care provider. Any unique cultural, social or language needs of the patients also need to be communicated. Planning is further complicated by the fact that some neighboring providers experience an initial increase in volume that dissipates

over time. In addition, facilities that have closed their OB units still receive pregnant patients at their emergency departments and need to be prepared to provide appropriate care. Trauma designation is also impacted by loss of the service.

Based on the interviews with providers who had closed OB units, the primary reason for OB unit closure in the region has been difficulty maintaining financial viability of this service. Liability costs and inadequate payments are strong contributing factors in this equation. A decline in patient volume due to changing demographics has also been a contributing factor.

Key questions to consider from the perspective of some of the hospitals that have been through this transition are shown below.

### **OB Unit Closure Key Questions**

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#### **Internal Considerations**

- How much advance notice should be given?
- Who needs to be notified internally of the decision, and when?
- Do you have a detailed internal communications plan developed?
- Do you have a plan to staff the service and maintain quality of care once an announcement is made to close the service?
- How will closure of this service impact the mission of the hospital?
- Who should be involved in the decision to close the service?
- What is the reason for discontinuing the service?
- Are there other options to consider besides closure of the service?
- Do you have enough data to make a conclusive decision?
- What will happen if you don't close the service?
- Will there be a new service that will replace the OB service?
- Will you have extra staff that is no longer needed as a result of the planned closure?
- Are there ancillary or support services that will be affected by the closure of this service?
- Does this service support other services that will be affected by its closure?
- Are there changes that will need to be made to the medical staff leadership structure as a result of the closure of this service?
- Are there contracts for services or equipment that are in place that will be affected by the closure of this service?
- Are there educational commitments that will be affected as a result of the closure of this service?

#### **External Considerations**

- Who needs to be notified externally of the decision, and when?
- Who are the nearest providers of this service for your community?
- Do you have a detailed external communications plan developed?

- Who will be affected by this decision?
  - Are there unique cultural, social or language needs for the patients of this service?
  - Are you prepared to deal with the questions from the media?
  - Will you have any equipment, supplies or other resources that will no longer be needed as a result of the planned closure?
  - Are there community groups that utilize this service that will be impacted?
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### **Recommendations:**

The Task Force recommends voluntary use of best practices, including the following:

- Adequate advance notice: The current notification requirement of the PA DoH is 90 days. The Task Force recommends that, if at all possible, more advance notice be given in order to allow for the smooth transition of patients to other providers and to allow those providers to prepare for the extra patient volume. However, experience at facilities that have closed a service indicates that it can be difficult to retain the skilled staff needed to keep the service operating once the announcement of closure has been given. Therefore, retention bonuses are often necessary to address the induced attrition.
- Transition plans for patients: Determining where current patients will obtain OB services, communicating with them appropriately, and arranging for transfer of medical records, where appropriate, to the new provider will help to assure seamless care.
- Early involvement of key stakeholders: Seek their help and input in making the decision, rather than just informing them that a decision has been made, and include board members, medical staff leadership, the OB department chair and department manager. The decision to close the service will also impact multiple key stakeholders, who need to be communicated with in a timely and appropriate manner, including: patients, employees, physicians, neighboring hospitals, community groups, insurance companies, local legislators and other elected officials as appropriate, government agencies, and unions.

## Conclusion

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Development of the Task Force report was truly a collaborative effort of many stakeholders who laid the foundation to move forward with addressing the many challenges currently faced by OB providers to assure access to quality OB and newborn services. We would like to thank all those who contributed so much of their time and expertise to the effort.

The Task Force review finds that there are serious threats to, if not actual loss of, access to services for some populations and some communities in our region. Further, there are growing signs that the stop-gap efforts by both hospitals and government will no longer be sufficient to ensure widespread access to this critical group of services. The situation demands action by all stakeholders.

Since the initiation of the Task Force and the development of the 10-Point Action Plan contained in this report, and because the threat to obstetric services also is challenging communities across the Commonwealth, the Delaware Valley Healthcare Council of HAP has presented a plan to The Hospital & Healthsystem Association of Pennsylvania (HAP) that emphasizes the importance of access to prenatal, OB and postpartum services in advocacy efforts to protect access to health care services and the integrity of the health care safety net.

Ensuring access to appropriate prenatal, maternity and postpartum services is an essential investment in our region's future. While society is confronted with many challenges when it comes to ensuring our children grow up to be productive and contributing members of our community, the Task Force believes that it is incumbent on all of us to make sure the appropriate services are available to give them the best possible start to that journey.

## **Acknowledgements**

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Development of the Task Force report was a collaborative effort of many stakeholders including providers, state and local health departments, consumer groups, and professional societies who are committed to addressing the many challenges currently impacting the provision of OB services. We would like to thank all those who contributed so much of their time and talent to the effort, in particular Kate Kinslow, CNRA, Ed.D, MBA, Executive Director, Pennsylvania Hospital, who chaired the Task Force and all the members of the Task Force and its work groups (see appendices). Many other individuals outside of the Task Force and work groups also contributed to the development of this report, including the PA DoH Bureau of Health Planning and Division of Statistical Registries. Task force activities related to workforce and addressing the needs of a diverse patient population were partially funded by a grant from the Aetna Foundation to support the provision of culturally competent care.

# Appendices

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## A. DVHC OB Services Task Force

**Kate Kinslow,**  
CRNA, Ed.D., MBA, Chair

**Pennsylvania Hospital**

### **Members:**

Meg McGoldrick  
Arnold W. Cohen, M.D.  
Jeffrey S. Gerdes, M.D.  
William McCune  
Andrew Wigglesworth  
Scott Levy, M.D.  
Laurie Durkin  
Linda Grass  
Nancy Roberts, M.D.  
Joan Zeidman, M.D.  
Joanne Fischer  
Joann Sansone, D.O.  
Joseph DiMino, D.O.  
Jan Nash  
Calvin Johnson, M.D.  
Melita J. Jordan, CNM, MSN  
Carmen I. Paris, M.P.H.  
Yvonne Stamm  
Robert Haggerty, M.D.  
Eric Mankin, M.D.  
Enrique Hernandez, M.D.

Abington Memorial Hospital  
Albert Einstein Medical Center  
CHOP Newborn Care at Pennsylvania Hospital  
Crozer-Keystone Health System  
Delaware Valley Healthcare Council of HAP  
Doylestown Hospital  
Hahnemann University Hospital  
Jeanes Hospital  
Lankenau Hospital  
Main Line Health System  
Maternity Care Coalition  
Mercy Suburban Hospital  
Montgomery County Health Department  
Paoli Hospital  
Pennsylvania Department of Health  
Pennsylvania Department of Health  
Philadelphia Department of Public Health  
Pottstown Memorial Medical Center  
Riddle Memorial Hospital  
Temple Physicians, Inc.  
Temple University School of Medicine

### **Guests:**

Joseph Morris  
Jim Redmond  
Denise Frasca, MSN, RN  
Letty Thall  
Barbara Hand  
Barbara O'Malley  
Katherine Maus  
Brenda Sheilds

Health Care Improvement Foundation  
Hospital and Healthsystem Association of PA  
Jeanes Hospital  
Maternity Care Coalition  
Montgomery County Health Department  
Montgomery County Health Department  
Philadelphia Department of Public Health  
Philadelphia Department of Public Health

### **DVHC Team:**

Mark Baumel, M.D.  
Pamela Clarke  
Priscilla Koutsouradis  
Alan Larson  
Lesley Stearns

## B. Work Groups

### Reimbursement and Liability Work Group

The reimbursement and liability work group was charged with examining and formulating recommendations for action by the OB Services Task Force on issues related to OB reimbursement and liability, including identifying the information that needs to be put before the legislature to support the recommendations of the Task Force on these issues.

<b>Name</b>	<b>Hospital/Organization</b>
Meg McGoldrick	Abington Memorial Hospital
Arnold Cohen, M.D.	Albert Einstein Medical Center
William McCune	Crozer Keystone Health System
Mark Baumel, M.D.	Delaware Valley Healthcare Council of HAP
Pamela Clarke	Delaware Valley Healthcare Council of HAP
Roger Lukoff	Delaware Valley Healthcare Council of HAP
Jane Porcelan, M.D., J.D.	Lankenau Hospital
Joanne Fischer	Maternity Care Coalition
Marge Angert, D.O.	Philadelphia Department of Public Health
Tracey Clark	Temple University Physicians
Jay Sial	Thomas Jefferson University Hospital

### Diversity and Workforce Work Group

The diversity and workforce work group was charged with examining how regional OB services can best meet the needs of a diverse population and also assure adequate OB workforce. The work group also provided input on tailoring the DVHC cultural competency initiative to meet the needs of OB services.

<b>Name</b>	<b>Hospital/Organization</b>
John P. Maher, M.D., M.P.H.	Chester County Department of Health
Maureen Hennessey Herman, Ed.D.	Intercommunity Health Coordination County of Delaware
Jay Feldstein, D.O.	Keystone Mercy Health Plan
Maryann Measure, M.S.S.	Maternal and Child Health Consortium of Chester County
Letty Thall	Maternity Care Coalition
Cathy Fizzano	Mercy Health System
Barbara Hand	Montgomery County Health Department
Barbara O'Malley	Montgomery County Health Department
Melita J. Jordan, CNM, MSN	Pennsylvania Department of Health
Kathleen Kennedy	SEPA Area Health Education Center
Gwendolyn A. Smith	Springfield Hospital
Enrique Hernandez, M.D.	Temple University School of Medicine

## Data Issues Work Group

The data issues work group was charged with examining and formulating recommendations for action by the OB Services Task Force on OB data related issues, including the following:

- City and State reporting requirements, i.e. birth certificates
- Mechanisms to monitor and manage NICU demand, similar to trauma services and ED services

Additional indicators needed to monitor quality and access issues, focusing on those related to Task Force major issues, such as NICU licensing.

### Name

Arnold Cohen, M.D.  
Jeffrey S. Gerdes, M.D.

Jennifer Kolker, M.P.H.  
Joel Telles, Ph.D.  
Barbara O'Malley  
Rackell Arum  
Cynthia Line, Ph.D.  
Katherine Maus  
Steve Carson  
Carolyn Gorman

### Hospital/Organization

Albert Einstein Medical Center  
CHOP Newborn Care at Pennsylvania  
Hospital  
Drexel University School of Public Health  
Main Line Health System  
Montgomery County Health Department  
Philadelphia Department of Public Health  
Philadelphia Department of Public Health  
Philadelphia Department of Public Health  
Temple University Health System  
University of Pennsylvania Health System

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